

AMENDED IN ASSEMBLY AUGUST 24, 1999

AMENDED IN ASSEMBLY AUGUST 16, 1999

AMENDED IN ASSEMBLY JULY 8, 1999

AMENDED IN SENATE MAY 19, 1999

AMENDED IN SENATE MAY 6, 1999

AMENDED IN SENATE APRIL 26, 1999

SENATE BILL

No. 870

Introduced by Senator Vasconcellos

February 25, 1999

An act to amend Sections 10232.1, 10232.2, 10232.3, 10232.4, 10233.2, 10233.5, 10235.2, 10235.8, 10235.30, 10235.40, 10235.50, 10235.52, 10237.1, 10237.4, and 10237.5 of, to add Sections 10232.97 and 10235.94 to, and to repeal and add Section 10232.92 of, the Insurance Code, relating to long-term care insurance.

LEGISLATIVE COUNSEL'S DIGEST

SB 870, as amended, Vasconcellos. Long-term care insurance.

Existing law prescribes various requirements and conditions governing the delivery or issuance for delivery in this state of individual or group long-term care insurance.

This bill would make various changes to those provisions, including changes clarifying an insurer's obligations to file, offer, and market policies intended to be federally qualified and policies that are not intended to be federally qualified;

changes mandating coverage for care in a residential care facility; changes relating to coverage for preexisting conditions; changes regarding prohibited policy provisions and prohibited insurer actions in connection with policies; and changes regarding the right of a policy or certificate holder to appeal decisions regarding benefit eligibility, care plans, services and providers, and reimbursements.

Vote: majority. Appropriation: no. Fiscal committee: no. State-mandated local program: no.

The people of the State of California do enact as follows:

1 SECTION 1. Section 10232.1 of the Insurance Code is
2 amended to read:

3 10232.1. (a) Every policy that is intended to be a
4 qualified long-term care insurance contract as provided
5 by Public Law 104-191 shall be identified as such by
6 prominently displaying and printing on page one of the
7 policy form and the outline of coverage and in the
8 application the following words: “This contract for
9 long-term care insurance is intended to be a federally
10 qualified long-term care insurance contract and may
11 qualify you for federal and state tax benefits.” Every
12 policy that is not intended to be a qualified long-term care
13 insurance contract as provided by Public Law 104-191
14 shall be identified as such by prominently displaying and
15 printing on page one of the policy form and the outline
16 of coverage and in the application the following words:
17 “This contract for long-term care insurance is not
18 intended to be a federally qualified long-term care
19 insurance contract.”

20 (b) Any policy or certificate in which benefits are
21 limited to the provision of institutional care shall be called
22 a “nursing facility and residential care facility only”
23 policy or certificate and the words “Nursing Facility and
24 Residential Care Facility Only” shall be prominently
25 displayed on page one of the form and the outline of
26 coverage. The commissioner may approve alternative
27 wording if it is more descriptive of the benefits.



(c) Any policy or certificate in which benefits are limited to the provision of home care services, including community-based services, shall be called a “home care only” policy or certificate and the words “Home Care Only” shall be prominently displayed on page one of the form and the outline of coverage. The commissioner may approve alternative wording if it is more descriptive of the benefits.

(d) Only those policies or certificates providing benefits for both institutional care and home care may be called “comprehensive long-term care” insurance.

SEC. 2. Section 10232.2 of the Insurance Code is amended to read:

10232.2. (a) Every insurer that offers policies or certificates that are intended to be federally qualified long-term care insurance contracts, including riders to life insurance policies providing long-term care coverage, shall fairly and affirmatively concurrently file, offer, and market long-term care insurance policies or certificates not intended to be federally qualified, as described in subdivision (a) of Section 10232.1.

(b) All long-term care insurance contracts, including riders to life insurance contracts providing long-term care coverage, approved after the effective date of this section shall meet all of the requirements of this chapter.

(c) Until July 1, 2001, or 90 days after approval of contracts submitted for approval pursuant to subdivision (b), whichever comes first, insurers may continue to offer and market previously approved long-term care insurance contracts.

(d) Group policies issued prior to January 1, 1997, shall be allowed to remain in force and not be required to meet the requirements of this chapter, as amended during the 1997 portion of the 1997–98 Regular Session, unless those policies cease to be treated as federally qualified long-term care insurance contracts. If a policy or certificate issued on a group policy of that type ceases to be a federally qualified long-term care insurance contract under the grandfather rules issued by the United States Department of the Treasury pursuant to Section

1 7702B(f)(2) of the Internal Revenue Code, the insurer
2 shall offer the policy and certificate holders the option to
3 convert, on a guaranteed-issue basis, to a policy or
4 certificate that is federally tax qualified if the insurer sells
5 tax-qualified policies.

6 SEC. 3. Section 10232.3 of the Insurance Code is
7 amended to read:

8 10232.3. (a) All applications for long-term care
9 insurance except that which is guaranteed issue, shall
10 contain clear, unambiguous, short, simple questions
11 designed to ascertain the health condition of the
12 applicant. Each question shall contain only one health
13 status inquiry and shall require only a “yes” or “no”
14 answer, except that the application may include a request
15 for the name of any prescribed medication and the name
16 of a prescribing physician. If the application requests the
17 name of any prescribed medications or prescribing
18 physicians, then any mistake or omission shall not be used
19 as a basis for the denial of a claim or the rescission of a policy
20 or certificate.

21 (b) The following warning shall be printed
22 conspicuously and in close conjunction with the
23 applicant’s signature block:

24 “Caution: If your answers on this application are
25 misstated or untrue, the insurer may have the right to
26 deny benefits or rescind your coverage.”

27 (c) Every application for long-term care insurance
28 shall include a checklist that enumerates each of the
29 specific documents which this chapter requires be given
30 to the applicant at the time of solicitation. The documents
31 and notices to be listed in the checklist include, but are
32 not limited to, the following:

33 (1) The “Important Notice Regarding Policies
34 Available” pursuant to Section 10232.25.

35 (2) The outline of coverage pursuant to Section
36 10233.5.

37 (3) The HICAP notice pursuant to paragraph (8) of
38 subdivision (a) of Section 10234.93.

1 (4) The long-term care insurance shoppers guide
2 pursuant to paragraph (9) of subdivision (a) of Section
3 10234.93.

4 (5) The “Long-Term Care Insurance Personal
5 Worksheet” pursuant to subdivision (c) of Section
6 10234.95.

7 (6) The “Notice to Applicant Regarding Replacement
8 of Accident and Sickness or Long-Term Care Insurance”
9 pursuant to Section 10235.16 if replacement is not made
10 by direct response solicitation or Section 10235.18 if
11 replacement is made by direct response solicitation.
12 Unless the solicitation was made by a direct response
13 method, the agent and applicant shall both sign at the
14 bottom of the checklist to indicate the required
15 documents were delivered and received.

16 (d) If an insurer does not complete medical
17 underwriting and resolve all reasonable questions arising
18 from information submitted on or with an application
19 before issuing the policy or certificate, then the insurer
20 may only rescind the policy or certificate or deny an
21 otherwise valid claim, upon clear and convincing
22 evidence of fraud or material misrepresentation of the
23 risk by the applicant. The evidence shall:

24 (1) Pertain to the condition for which benefits are
25 sought.

26 (2) Involve a chronic condition or involve dates of
27 treatment before the date of application.

28 (3) Be material to the acceptance for coverage.

29 (e) No long-term care policy or certificate may be field
30 issued.

31 (f) The contestability period as defined in Section
32 10350.2 for long-term care insurance shall be two years.

33 (g) A copy of the completed application shall be
34 delivered to the insured at the time of delivery of the
35 policy or certificate.

36 (h) Every insurer shall maintain a record, in
37 accordance with Section 10508, of all policy or certificate
38 rescissions, both state and countrywide, except those
39 voluntarily initiated by the insured, and shall annually

1 furnish this information to the commissioner in a format
2 prescribed by the commissioner.

3 SEC. 4. Section 10232.4 of the Insurance Code is
4 amended to read:

5 10232.4. (a) No long-term care insurance policy or
6 certificate other than a group policy or certificate, as
7 described in subdivision (a) of Section 10231.6, shall use
8 a definition of preexisting condition which is more
9 restrictive than a condition for which medical advice or
10 treatment was recommended by, or received from a
11 provider of health care services, within six months
12 preceding the effective date of coverage of an insured
13 person.

14 (b) Every long-term care insurance policy or
15 certificate shall cover preexisting conditions that are
16 disclosed on the application no later than six months
17 following the effective date of the coverage of an insured,
18 regardless of the date the loss or confinement begins.

19 (c) The definition of preexisting condition does not
20 prohibit an insurer from using an application form
21 designed to elicit the complete health history of an
22 applicant, and on the basis of the answers on that
23 application, from underwriting in accordance with that
24 insurer's established underwriting standards. Unless
25 otherwise provided in the policy or certificate a
26 preexisting condition, regardless of whether it is disclosed
27 on the application, need not be covered until the waiting
28 period described in subdivision (b) expires. Unless a
29 waiver or rider has been specifically approved by the
30 commissioner, no long-term care insurance policy or
31 certificate may exclude or use waivers or riders of any
32 kind to exclude, limit, or reduce coverage or benefits for
33 specifically named or described preexisting diseases or
34 physical conditions beyond the waiting period described
35 in subdivision (b).

36 SEC. 5. Section 10232.92 of the Insurance Code is
37 repealed.

38 SEC. 6. Section 10232.92 is added to the Insurance
39 Code, to read:



1 10232.92. Every long-term care policy or certificate
2 and every benefit covering confinement in a nursing
3 facility shall also include a provision with the following
4 features:

5 (a) Care in a residential care facility must be covered.
6 “Residential care facility” means a facility licensed as a
7 residential care facility for the elderly or a residential care
8 facility as defined in the Health and Safety Code. Outside
9 California, eligible providers are facilities that are
10 engaged primarily in providing ongoing care and related
11 services sufficient to support needs resulting from
12 impairment in activities of daily living or impairment in
13 cognitive ability and which also provide care and services
14 on a 24-hour basis, have a trained and ready-to-respond
15 employee on duty in the facility at all times to provide
16 care and services, provide three meals a day and
17 accommodate special dietary needs, have agreements to
18 ensure that residents receive the medical care services of
19 a physician or nurse in case of emergency, and, have
20 appropriate methods and procedures to provide
21 necessary assistance to residents in the management of
22 prescribed medications.

23 (b) The benefit amount payable for care in a
24 residential care facility shall be no less than 70 percent of
25 the benefit amount payable for institutional confinement.

26 (c) All expenses incurred by the insured while
27 confined in a residential care facility, for long-term care
28 services that are necessary diagnostic, preventative,
29 therapeutic, curing, treating, mitigating, and
30 rehabilitative services, and maintenance or personal care
31 services, needed to assist the insured with the disabling
32 conditions that cause the insured to be a chronically ill
33 individual, shall be covered and payable, up to but not to
34 exceed the maximum daily residential care facility
35 benefit of the policy or certificate. There shall be no
36 restriction on who may provide the service or the
37 requirement that services be provided by the residential
38 care facility, and no restriction on the type of service,
39 supply, or expenses incurred that are covered or the
40 amounts that are reimbursable as long as the expenses are

1 incurred while the insured is confined in a residential
2 care facility ~~and~~, the reimbursement does not exceed the
3 maximum daily residential care facility benefit of the
4 policy or certificate, *and the services do not conflict with*
5 *federal law or regulation for purposes of qualifying for*
6 *favorable tax consideration provided by Public Law*
7 *104-191.*

8 (d) In policies or certificates that are not intended to
9 be federally qualified, the threshold establishing
10 eligibility for care in a residential care facility shall be the
11 same as for home care benefits, as defined in subdivision
12 (a) of Section 10232.8, and the definitions of impairment
13 in activities of daily living and impairment of cognitive
14 ability shall be the same as for home care benefits, as
15 defined in subdivisions (a) and (g) of Section 10232.8. In
16 policies or certificates that are intended to be federally
17 qualified, the threshold establishing eligibility for care in
18 a residential care facility shall be the same as for home
19 care benefits, as defined in subdivision (b) of Section
20 10232.8, and the definitions of impairment in activities of
21 daily living and impairment in cognitive ability shall be
22 the same as those for home care benefits as defined in
23 subdivisions (b), (c), (d), (e), and (f) of Section 10232.8.

24 SEC. 7. Section 10232.97 is added to the Insurance
25 Code, to read:

26 10232.97. In every long-term care policy or certificate
27 that covers care in a nursing facility, the threshold
28 establishing eligibility for nursing facility care shall be no
29 more restrictive than a provision that the insured will
30 qualify if either one of two criteria are met:

31 (a) Impairment in two activities of daily living.

32 (b) Impairment in cognitive ability.

33 SEC. 8. Section 10233.2 of the Insurance Code is
34 amended to read:

35 10233.2. Long-term care insurance may not:

36 (a) Be canceled, nonrenewed, or otherwise
37 terminated on the grounds of the age or the deterioration
38 of the mental or physical health of the insured individual
39 or certificate holder.

(b) Contain a provision establishing a new waiting period in the event existing coverage is converted to, or replaced by, a new or other form within the same insurer, except with respect to an increase in benefits voluntarily selected by the insured individual or group policyholder.

(c) Provide coverage for skilled nursing care only or provide significantly more coverage for skilled care in a facility than coverage for lower levels of care.

(d) Provide for payment of benefits based on a standard described as “usual and customary,” “reasonable and customary,” or words of similar import.

(e) Terminate a policy, certificate, or rider, or contain a provision that allows the premium for an in-force policy, certificate, or rider, to be increased due to the divorce of a policyholder or certificate holder.

(f) Include an additional benefit for a service with a known market value other than the statutorily required home- and community-based service benefits in Section 10232.9, the assisted living benefit in Section 10232.92, or a nursing facility benefit, unless the additional benefit provides for the payment of at least five times the daily benefit and the dollar value of the additional benefit is disclosed in the schedule page of the policy.

SEC. 9. *Section 10233.5 of the Insurance Code is amended to read:*

10233.5. (a) An outline of coverage shall be delivered to a prospective applicant for long-term care insurance at the time of initial solicitation through means which prominently direct the attention of the recipient to the document and its purpose.

(b) In the case of agent solicitations, an agent shall deliver the outline of coverage prior to the presentation of an application or enrollment form.

(c) In the case of direct response solicitations, the outline of coverage shall be presented in conjunction with any application or enrollment form.

(d) The outline of coverage shall be a freestanding document, using no smaller than 10-point type.

(e) The outline of coverage shall contain no material of an advertising nature.

(f) Use of the text and sequence of the text of the outline of coverage set forth in this section is mandatory, unless otherwise specifically indicated.

(g) Text which is capitalized or underscored in the outline of coverage may be emphasized by other means which provide prominence equivalent to capitalization or underscoring.

(h) The outline of coverage shall be in the following form:

“(COMPANY NAME)

(ADDRESS—CITY AND STATE)

(TELEPHONE NUMBER)

LONG-TERM CARE INSURANCE

OUTLINE OF COVERAGE

(Policy Number or Group Master Policy and
Certificate Number)

1. This policy is (an individual policy of insurance) ((a group policy) which was issued in the (indicate jurisdiction in which group policy was issued)).

2. PURPOSE OF OUTLINE OF COVERAGE. This outline of coverage provides a very brief description of the important features of the policy. You should compare this outline of coverage to outlines of coverage for other policies available to you. This is not an insurance contract, but only a summary of coverage. Only the individual or group policy contains governing contractual provisions. This means that the policy or group policy sets forth in detail the rights and obligations of both you and the insurance company. Therefore, if you purchase this coverage, or any other coverage, it is important that you READ YOUR POLICY (OR CERTIFICATE) CAREFULLY!

1 3. TERMS UNDER WHICH THE POLICY OR
2 CERTIFICATE MAY BE RETURNED AND PREMIUM
3 REFUNDED.

4 (a) Provide a brief description of the right to
5 return—"free look" provision of the policy.

6 (b) Include a statement that the policy either does or
7 does not contain provisions providing for a refund or
8 partial refund of premium upon the death of an insured
9 or surrender of the policy or certificate. If the policy
10 contains those provisions, include a description of them.

11 4. THIS IS NOT MEDICARE SUPPLEMENT
12 COVERAGE. If you are eligible for Medicare, review the
13 Medicare Supplement Buyer's Guide available from the
14 insurance company.

15 (a) (For agents) Neither (insert company name) nor
16 its agents represent Medicare, the federal government or
17 any state government.

18 (b) (For direct response) (insert company name) is
19 not representing Medicare, the federal government or
20 any state government.

21 5. LONG-TERM CARE COVERAGE. Policies of this
22 category are designed to provide coverage for one or
23 more necessary or medically necessary diagnostic,
24 preventive, therapeutic, rehabilitative, maintenance, or
25 personal care services, provided in a setting other than an
26 acute care unit of a hospital, such as in a nursing home, in
27 the community, or in the home.

28 This policy provides coverage in the form of a fixed
29 dollar indemnity benefit for covered long-term care
30 expenses, subject to policy (limitations) (waiting
31 periods) and (coinsurance) requirements. (Modify this
32 paragraph if the policy is not an indemnity policy.)

33 6. BENEFITS PROVIDED BY THIS POLICY.

34 (a) (Covered services, related deductible(s), waiting
35 periods, elimination periods, and benefit maximums.)

36 (b) (Institutional benefits, by skill level.)

37 (c) (Noninstitutional benefits, by skill level.)

38 (Any benefit screens must be explained in this section.
39 If these screens differ for different benefits, explanation
40 of the screen should accompany each benefit description.

1 If an attending physician or other specified person must
2 certify a certain level of functional dependency in order
3 to be eligible for benefits, this too must be specified. If
4 activities of daily living (ADLs) are used to measure an
5 insured's need for long-term care, then these qualifying
6 criteria or screens must be explained.)

7 7. LIMITATIONS AND EXCLUSIONS.

8 (Describe:

9 (a) Preexisting conditions.

10 (b) Noneligible facilities/provider.

11 (c) Noneligible levels of care (e.g., unlicensed
12 providers, care or treatments provided by a family
13 member, etc.).

14 (d) Exclusions/exceptions.

15 (e) Limitations.)

16 (This section should provide a brief specific description
17 of any policy provisions which limit, exclude, restrict,
18 reduce, delay, or in any other manner operate to qualify
19 payment of the benefits described in (6) above.)

20 THIS POLICY MAY NOT COVER ALL THE
21 EXPENSES ASSOCIATED WITH YOUR LONG-TERM
22 CARE NEEDS.

23 8. RELATIONSHIP OF COST OF CARE AND
24 BENEFITS. Because the costs of long-term care services
25 will likely increase over time, you should consider
26 whether and how the benefits of this plan may be
27 adjusted. (As applicable, indicate the following:

28 (a) That the benefit level will NOT increase over time.

29 (b) Any automatic benefit adjustment provisions.

30 (c) Whether the insured will be guaranteed the option
31 to buy additional benefits and the basis upon which
32 benefits will be increased over time if not by a specified
33 amount or percentage.

34 (d) If there is a guarantee, include whether additional
35 underwriting or health screening will be required, the
36 frequency and amounts of the upgrade options, and any
37 significant restrictions or limitations.

38 (e) And finally, describe whether there will be any
39 additional premium charge imposed, and how that is to
40 be calculated.)

1 9. TERMS UNDER WHICH THE POLICY (OR
2 CERTIFICATE) MAY BE CONTINUED IN FORCE OR
3 DISCONTINUED.

4 (a) Describe the policy renewability provisions.

5 (b) For group coverage, specifically describe
6 continuation/conversion provisions applicable to the
7 certificate and group policy.

8 (c) Describe waiver of premium provisions or state
9 that there are no waiver of premium provisions.

10 (d) State whether or not the company has a right to
11 change premium, and if that right exists, describe clearly
12 and concisely each circumstance under which the
13 premium may change.

14 10. ~~ALZHEIMER'S DISEASE AND OTHER~~
15 ~~ORGANIC BRAIN DISORDERS~~ *ALZHEIMER'S*
16 *DISEASE, ORGANIC MENTAL DISORDERS, AND*
17 *MENTAL DISEASES.*

18 (State that the policy provides coverage for insureds
19 clinically diagnosed as having Alzheimer's Disease,
20 *organic mental disorders, mental diseases*, or related
21 degenerative and dementing illnesses. Specifically
22 describe each benefit screen or other policy provision
23 that provides preconditions to the availability of policy
24 benefits for that insured.)

25 11. PREMIUM.

26 (a) State the total annual premium for the policy.

27 (b) If the premium varies with an applicant's choice
28 among benefit options, indicate the portion of annual
29 premium which corresponds to each benefit option.

30 12. ADDITIONAL FEATURES.

31 (a) Indicate if medical underwriting is used.

32 (b) Describe other important features.

33 13. INFORMATION AND COUNSELING. The
34 California Department of Insurance has prepared a
35 Consumer Guide to Long-Term Care Insurance. This
36 guide can be obtained by calling the Department of
37 Insurance toll-free telephone number. This number is
38 1-800-927-HELP. Additionally, the Health Insurance
39 Counseling and Advocacy Program (HICAP)
40 administered by the California Department of Aging,

1 provides long-term care insurance counseling to
2 California senior citizens. Call the HICAP toll-free
3 telephone number 1-800-434-0222 for a referral to your
4 local HICAP office.”

5 SEC. 9.5. Section 10235.2 of the Insurance Code is
6 amended to read:

7 10235.2. No long-term care insurance policy
8 delivered or issued for delivery in this state shall use the
9 terms set forth below, unless the terms are defined in the
10 policy and the definitions satisfy the following
11 requirements:

12 (a) “Medicare” shall be defined as the “Health
13 Insurance for the Aged Act,” Title XVIII of the Social
14 Security Amendments of 1965 as then constituted or later
15 amended, or Title I, Part I of Public Law 89-97, as enacted
16 by the 89th Congress of the United States of America and
17 popularly known as the Health Insurance for the Aged
18 Act, as then constituted and any later amendments or
19 substitutes thereof, or words of similar import.

20 (b) “Skilled nursing care,” “intermediate care,”
21 “home health care,” and other services shall be defined
22 in relation to the level of skill required, the nature of the
23 care and the setting in which care is required to be
24 delivered.

25 (c) All providers of services, including, but not limited
26 to, skilled nursing facilities, intermediate care facilities,
27 and home health agencies shall be defined in relation to
28 the services and facilities required to be available and the
29 licensure or degree status of those providing or
30 supervising the services. The definition may require that
31 the provider be appropriately licensed or certified.

32 SEC. 10. Section 10235.8 of the Insurance Code is
33 amended to read:

34 10235.8. No policy may be delivered or issued for
35 delivery in this state as long-term care insurance if the
36 policy limits or excludes coverage by type of illness,
37 treatment, medical condition, or accident, except as to
38 the following:

39 (a) Preexisting conditions or diseases.

40 (b) Alcoholism and drug addiction.

(c) Illness, treatment, or a medical condition arising out of any of the following:

(1) War or act of war, whether declared or undeclared.

(2) Participation in a felony, riot, or insurrection.

(3) Service in the armed forces or units auxiliary thereto.

(4) Suicide, whether sane or insane, attempted suicide, or intentionally self-inflicted injury.

(5) Aviation in the capacity of a non-fare-paying passenger.

(d) Treatment provided in a government facility, unless otherwise required by law, services for which benefits are available under Medicare or other governmental programs (except Medi-Cal or medicaid), any state or federal workers' compensation, employer's liability or occupational disease law, or any motor vehicle no fault law, services provided by a member of the covered person's immediate family, and services for which no charge is normally made in the absence of insurance.

This section does not prohibit exclusions and limitations by type of provider or territorial limitations.

SEC. 11. Section 10235.30 of the Insurance Code is amended to read:

10235.30. (a) No insurer may deliver or issue for delivery a long-term care policy in this state unless the insurer offers at the time of application an option to purchase a shortened benefit period nonforfeiture benefit with the following features:

(1) Eligibility begins no later than after 10 years of premium payments.

(2) The lifetime maximum benefit is no less than the dollar equivalent of three months of care at the nursing facility per diem benefit contained in the policy or the amount of the premiums paid, whichever is greater.

(3) The same benefits covered in the policy and any riders at the time eligibility begins are payable for a qualifying claim.

(4) The lifetime maximum benefit may be reduced by the amount of any claims already paid.

(5) Cash back, extended term, and reduced paid-up forms of nonforfeiture benefits shall not be allowed.

(6) The lifetime maximum benefit amount increases proportionally with the number of years of premium payment.

(b) This section shall not apply to life insurance policies that accelerate benefits for long-term care.

SEC. 12. Section 10235.40 of the Insurance Code is amended to read:

10235.40. (a) No individual long-term care policy or certificate shall be issued until the applicant has been given the right to designate at least one individual, in addition to the applicant, to receive notice of lapse or termination of a policy or certificate for nonpayment of premium. The insurer shall receive from each applicant one of the following:

(1) A written designation listing the name, address, and telephone number of at least one individual, in addition to the applicant, who is to receive notice of lapse or termination of the policy or certificate for nonpayment of premium.

(2) A waiver signed and dated by the applicant electing not to designate additional persons to receive notice. The required waiver shall read as follows:

“Protection Against Unintended Lapse.

I understand that I have the right to designate at least one person other than myself to receive notice of lapse or termination of this long-term care insurance policy for nonpayment of premium. I understand that notice will not be given until 30 days after a premium is due and unpaid. I elect not to designate any person to receive the notice.

Signature of Applicant

Date”

(b) The insurer shall notify the insured of the right to change the written designation, no less often than once every two years.

(c) When the policyholder or certificate holder pays the premium for a long-term care insurance policy or certificate through a payroll or pension deduction plan, the requirements contained in subdivision (a) need not be met until 60 days after the policyholder or certificate holder is no longer on that deduction payment plan. The application or enrollment form for a certified long-term care insurance policy or certificate shall clearly indicate the deduction payment plan selected by the applicant.

(d) No individual long-term care policy or certificate shall lapse or be terminated for nonpayment of premium unless the insurer, at least 30 days prior to the effective date of the lapse or termination, gives notice to the insured and to the individual or individuals designated pursuant to subdivision (a), at the address provided by the insured for purposes of receiving notice of lapse or termination. Notice shall be given by first-class United States ~~certified~~ mail, postage prepaid, not less than 30 days after a premium is due and unpaid.

(e) Each long-term care insurance policy or certificate shall include a provision which, in the event of lapse, provides for reinstatement of coverage, if the insurer is provided with proof of the insured's cognitive impairment or the loss of functional capacity. This option shall be available to the insured if requested within five months after termination and shall allow for the collection of a past due premium, where appropriate. The standard of proof of cognitive impairment or loss of functional capacity shall not be more stringent than the benefit eligibility criteria on cognitive impairment or the loss of functional capacity contained in the policy certificate.

SEC. 13. Section 10235.50 of the Insurance Code is amended to read:

10235.50. Every policy or certificate shall include a provision that gives the policyholder or certificate holder

1 the following rights to reduce coverage and lower
2 premiums:

3 (a) A right, exercisable any time after the first year, to
4 retain a policy or certificate while lowering the premium
5 in no fewer than the following three ways:

6 (1) Reducing the lifetime maximum benefit.

7 (2) Reducing the nursing facility per diem and
8 reducing the home- and community-based service
9 benefits of a home care only policy and of a
10 comprehensive long-term care policy.

11 (3) Converting a “comprehensive long-term care”
12 policy or certificate to a “Nursing Facility Only” or a
13 “Home Care Only” policy or certificate, if the insurer
14 issues those policies or certificates for sale in the state.

15 (b) The premium for the policy or certificate that is
16 reduced in coverage will be based on the age of the
17 insured at issue age and the premium rate applicable to
18 the amount of reduced coverage at the original issue date.

19 (c) If the contract in force at the time a reduction in
20 coverage is made provides for benefit adjustments for
21 anticipated increases in the costs of long-term care
22 services, then the reduced nursing facility per diem,
23 lifetime maximum benefit, and daily, weekly, or monthly
24 home care benefits shall be adjusted in the same manner
25 and in the same amount as the contract in force prior to
26 the reduction in coverage.

27 (d) In the event a policy or certificate is about to lapse,
28 the insurer shall provide written notice to the insured of
29 the options in subdivision (a) to lower the premium by
30 reducing coverage and of the premiums applicable to the
31 reduced coverage options. The insurer may include in the
32 notice additional options to those required in subdivision
33 (a). The notice shall provide the insured at least 30 days
34 in which to elect to reduce coverage and the policy shall
35 be reinstated without underwriting if the insured elects
36 the reduced coverage.

37 (e) In the event of a premium increase, the insured
38 shall be offered the option to lower premiums and reduce
39 coverage.

1 SEC. 14. Section 10235.52 of the Insurance Code is
2 amended to read:

3 10235.52. (a) Every policy shall contain a provision
4 that, in the event the insurer develops new benefits or
5 benefit eligibility or new policies with new benefits or
6 benefit eligibility not included in the previously issued
7 policy, the insurer will grant current holders of its policies
8 who are not in benefit or within the elimination period
9 the following rights:

10 (1) The policyholder will be notified of the availability
11 of the new benefits or benefit eligibility or new policy
12 within 12 months. The insurer's notice shall be filed with
13 and approved by the department at the same time as the
14 new policy or rider.

15 (2) The insurer shall offer the policyholder new
16 benefits or benefit eligibility in one of the following ways:

17 (A) By adding a rider to the existing policy and paying
18 a separate premium for the new benefit or benefit
19 eligibility based on the insured's attained age. The
20 premium for the existing policy will remain unchanged
21 based on the insured's age at issuance.

22 (B) By replacing the existing policy or certificate in
23 accordance with Section 10234.87.

24 (C) By replacing the existing policy or certificate with
25 a new policy or certificate in which case consideration for
26 past insured status shall be recognized by setting the
27 premium for the replacement policy or certificate at the
28 issue age of the policy or certificate being replaced.

29 (b) The insured may be required to undergo new
30 underwriting, but the underwriting can be no more
31 restrictive than if the policyholder or certificate holder
32 were applying for a new policy or certificate.

33 (c) The insurer of a group policy as defined under
34 subdivisions (a) to (c), inclusive, of Section 10231.6 must
35 offer the group policyholder the opportunity to have the
36 new benefits and provisions extended to existing
37 certificate holders, but the insurer is relieved of the
38 obligations imposed by this section if the holder of the
39 group policy declines the issuer's offer.

1 SEC. 15. Section 10235.94 is added to the Insurance
2 Code, to read:

3 10235.94. Every policy or certificate shall include a
4 provision giving the policyholder or certificate holder the
5 right to appeal decisions regarding benefit eligibility,
6 care plans, services and providers, and reimbursement
7 payments.

8 SEC. 16. Section 10237.1 of the Insurance Code is
9 amended to read:

10 10237.1. No insurer may deliver or issue for delivery
11 a long-term care insurance policy or certificate in this
12 state unless the insurer offers to each policyholder and
13 certificate holder, in addition to any other inflation
14 protection, the option to purchase a long-term care
15 insurance policy or certificate that provides for benefit
16 levels and benefit maximums to increase to account for
17 reasonably anticipated increases in the costs of long-term
18 care services covered by the policy. Insurers shall offer to
19 each policyholder and certificate holder, at the time of
20 purchase, the option to purchase a long-term care
21 insurance policy or certificate containing an inflation
22 protection feature which is no less favorable than one that
23 does one or more of the following:

24 (a) Increases benefit levels annually in a manner so
25 that the increases are compounded annually at a rate of
26 not less than 5 percent.

27 (b) Guarantees the insured individual the right to
28 periodically increase benefit levels without providing
29 evidence of insurability or health status and without
30 regard to claim status or history so long as the option for
31 the previous period has not been declined. The amount
32 of the additional benefit shall be no less than the
33 difference between the existing policy benefit and that
34 benefit compounded annually at a rate of at least 5
35 percent for the period beginning with the purchase of the
36 existing benefit and extending until the year in which the
37 offer is made.

38 (c) Covers a specified percentage of actual or
39 reasonable charges and does not include a maximum
40 specified indemnity amount limit.

(d) The insurer of a group long-term care insurance policy as defined in subdivision (a), (b), or (c) of Section 10231.6, shall offer the holder of the group policy the opportunity to have the inflation protection pursuant to this section extended to existing certificate holders, but the insurer is relieved of the obligations imposed by this section if the holder of the group policy declines the insurer's offer.

SEC. 17. Section 10237.4 of the Insurance Code is amended to read:

10237.4. (a) Inflation protection benefit increases under a policy that contains these benefits shall continue without regard to an insured's age, claim status or claim history, or the length of time the person has been insured under the policy.

(b) An offer of inflation protection that provides for automatic benefit increases shall include an offer of a premium which the insurer expects to remain constant. The offer shall disclose in a conspicuous manner that the premium may change in the future unless the premium is guaranteed to remain constant.

(c) The inflation protection benefit increases under a policy or certificate that contains an inflation protection feature shall not be reduced due to the payment of claims.

SEC. 18. Section 10237.5 of the Insurance Code is amended to read:

10237.5. (a) An inflation protection provision that increases benefit levels annually in a manner so that the increases are compounded annually at a rate not less than 5 percent shall be included in a long-term care insurance policy unless an insurer obtains a rejection of inflation protection signed by the policyholder.

(b) The rejection, to be included in the application or on a separate form, shall state:

"I have reviewed the outline of coverage and the graphs that compare the benefits and premiums of this policy with and without inflation protection. Specifically, I have reviewed the plan, and I reject 5 percent annual compound inflation protection.

1	_____	_____
2	Signature of Applicant	Date”

